COMMENDING LIEUTENANT COLONEL MOSES WHITEHURST FOR SERVICES WELL-RENDERED

HON. WES COOLEY

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 10, 1995

Mr. COOLEY. Mr. Speaker, I rise today to recognize the service and the accomplishments of Lt. Col. Moses Whitehurst, Jr. who commanded Umatilla Depot Activity [UMDA], in Hermiston, OR from July 1993 to July 1995. Although continually challenged with mission changes, personnel reductions, dwindling resources, and short supplies, Moses Whitehurst performed his duties with vigor and professionalism while always meeting or exceeding requirements and expectations.

Lieutenant Colonel Whitehurst performed mission operations effectively as exhibited by successful completion of countless reviews and inspections. While under the command of Lieutenant Colonel Whitehurst, UMDA exceeded fiscal year 1994 conventional ammunition demilitarization forecasts by accomplishing 100 percent of the workload ahead of schedule. In addition, UMDA exceeded all expectations for shipment of ammunition stocks and general commodities by shipping more in fiscal year 1994 than had been shipped in the 4 previous years combined.

During Lieutenant Colonel Whitehurst's service, UMDA met or exceeded all BRAC time requirements. Through effective use of the one team approach, he has ensured a seamless transition for the operational control of the chemical stockpile mission from the Industrial Operations Command to the Chemical and Biological Defense Command.

By all accounts, Lt. Col. Moses Whitehurst has done an outstanding job of fulfilling all UMDA civic responsibilities and ensuring that a very positive public perception was maintained by the communities surrounding the installation. Under his command, UMDA was always well-represented at all meetings regarding CSEPP; in addition to hosting many local professional groups at UMDA, which included tours of the installation.

During his command tour at Umatilla Depot Activity, Lieutenant Colonel Moses Whitehurst set a tone of professionalism and teamwork. His exceptional leadership performance is a credit to himself, the Tooele Army Depot Complex, the Industrial Operations Command, and the U.S. Army. The people of the Second District and I are grateful to have had the benefit of his service.

TWA—NEW YORK TO LONDON

HON. WILLIAM (BILL) CLAY

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 10, 1995

Mr. CLAY. Mr. Speaker, I would like to share with this body an issue which is of great importance to the St. Louis community and vital to the future of one of our major domestic airlines, Trans World Airlines. TWA, which maintains its operating hub at Lambert International Airport in St. Louis, needs to regain its longstanding New York-London route authority.

I have joined my St. Louis area colleagues in urging the Department of Transportation to pursue this issue in behalf of TWA at the ongoing bilateral negotiations with United Kingdom representatives. I would like to take this opportunity to share the text of a letter which St. Louis Mayor Freeman Bosley recently sent to the Transportation Secretary Fredrico Peña. This communication clearly articulates the vital importance of TWA's request for New York to London route authority.

DEAR SECRETARY PEÑA: I am submitting this letter as Mayor of St. Louis in strong support of Trans World Airlines regaining its long-standing New York-London route authority in the current bilateral negotiations with the United Kingdom. It is essential that TWA—one of the nation's great pioneers of international service—not be left out of these negotiations.

TWA maintains its major hub operation at St. Louis and employs over 12,000 Missourians. This proposed New York-London (Gatwick) service would not directly affect Missouri (TWA already flies between St. Louis and Long-Gatwick), but it would go far toward rebuilding an airline attempting to escape the financial damage and job loss caused by less than satisfactory management for over six years.

TWA had served London since 1950 from several large U.S. gateways and all but the St. Louis authority was sold in 1991 and 1992. St. Louis opposed such sales and unsuccessfully appealed the Department's approval. Under new energetic management. TWA is now seeking to return to the New York-London market which was wrongfully given up by prior management and whose transfer was wrongfully approved by the prior Administration. The present Administration should be fairness to TWA and its new employee ownership move to redress that error and find a means to return to TWA its New York-London authority which was the backbone of its transatlantic route system. The current negotiations offer an ideal opportunity to accomplish this objective.

I also want to urge that TWA be granted St. Louis-Toronto authority as early as possible under the new U.S.-Canada agreement. St. Louis has been attempting for fifteen years to obtain nonstop St. Louis-Toronto service. The St. Louis area and the entire state of Missouri have an exceptionally strong community of interest with Toronto and Canada as a whole. Through all this period Toronto has continued to represent one of the major deficiencies in St. Louis air service. St. Louis clearly ranks very high on the nation's list of deprived cities as far as Canada is concerned. It is long past time to remedy this situation.

TWA's proposed St. Louis-Toronto service involves first nonstop operations to one of the largest U.S. service areas, would offer beyond traffic support unequaled by any other carrier and would provide the only effective means through one service proposal of meeting the Canada needs of both the Midwest and Western parts of the United States. TWA should definitely be one of the carriers selected for Toronto service in the second year of interim operation.

Further, St. Louis—in addition to its tremendous beyond area support—has a very strong traffic base in its own area. St. Louis is the nation's fifth ranking Fortune 500 company headquarters city and was ranked by World Trade magazine as one of the ten best U.S. cities for international companies. Substantial numbers of St. Louis area companies have major business ties to Canada. The Canadian business investment in the St. Louis area is similarly substantial and long standing in nature. According to Canadian data (Canadian Consulate, Chicago) total Missouri exports to Canada were $1.934 billion in 1993 and Canadian exports to Missouri were $1.435 billion in that year. Trade between Canada and Missouri is about the same as that between Canada and Mexico.

In the interest of building a sound airline industry, it is high time that the Department look away from the mega-carriers such as American, Delta, Northwest and United in favor of competition. TWA's London and Toronto requests are fully in accord with the Administration's consistent position that there should be increase competition—not less—in the airline industry.

Moreover, there are unique reasons for finding ways to strengthen TWA. The most important of these is the fact that TWA is under new ownership by its own employees. TWA's employees now own 45 percent of the voting stock of the carrier, an equity interest for which the employees are paying substantial amounts in hard earned wages. These employees have incredible dedication to the success of the carrier. This development—the employee-ownership reorganization of TWA—represented the first successful equity reorganization of this nature in the industry and constitutes a model for subsequent airline restructuring. It should be encouraged by the Department.

Further, TWA has demonstrated great determination to reform itself by completely overthrowing its old management and by developing new service concepts that truly attempt to met public needs. It was able to effect its major ownership and management change and come through a painful reorganization under Chapter 11 in an expeditious and successful fashion. It is now undergoing a further financial restructuring to strengthen its operation. These efforts by TWA's employee owners deserve to be recognized by the Department as a major favorable development in an airline industry that has seen too few favorable developments in recent years.

In achieving its turnaround, TWA has been able to preserve one of the great historic names in the international aviation arena. TWA was a true pioneer of international operations and its name continues to command respect abroad. It is only right that the Department move to strengthen the carrier in the international arena and grant it strong London and Toronto routes which will materially aid its operations while at the same time meeting clear public needs. I appreciate your consideration of these matters which are vital to TWA's future.

Sincerely,

FREEMAN R. BOSLEY, JR.,
Mayor.

WORKING FAMILIES HEALTH ACCESS ACT

HON. NANCY L. JOHNSON

OF CONNECTICUT

IN THE HOUSE OF REPRESENTATIVES

Wednesday, May 10, 1995

Mrs. JOHNSON of Connecticut. Mr. Speaker, as a step toward creating a national health care policy that assures continuity of coverage for all working Americans, I am introducing the Working Families Health Access Act of 1995 and invite your co-sponsorship.

The text of the bill follows:

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Working Families Health Access Act of 1995''.

SEC. 2. PROMOTING THE CONTINUITY AND PORTABILITY OF HEALTH COVERAGE.

(a) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by inserting after chapter 44 the following new chapter:

''CHAPTER 45—CONTINUITY AND PORTABILITY OF HEALTH COVERAGE

''SEC. 4986. IMPOSITION OF TAX FOR FAILURE TO MEET CONTINUITY AND PORTABILITY STANDARDS.

''(a) INSURED HEALTH PLANS.—

''(1) IN GENERAL.—In the case of any health insurance policy which fails to meet the applicable standards specified in this chapter at any time during a calendar year, there is hereby imposed a tax equal to 25 percent of the premiums received under such policy during the calendar year.

''(2) LIABILITY FOR TAX.—The tax imposed by paragraph (1) shall be paid by the issuer of the policy.

''(3) TREATMENT OF PREPAID HEALTH COVERAGE.—For purposes of this subsection:

''(A) IN GENERAL.—In the case of any prepaid health arrangement—

''(i) such arrangement shall be treated as a health insurance policy,

''(ii) the payments or premiums referred to in subparagraph (B)(i) shall be treated as premiums received for a health insurance policy, and

''(iii) the person referred to in subparagraph (B)(i) shall be treated as the issuer.

''(B) PREPAID HEALTH ARRANGEMENT.—For purposes of subparagraph (A), the term 'prepaid health arrangement' means an arrangement under which—

''(i) fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage regardless of how such coverage is provided or arranged to be provided, and

''(ii) substantially all the risks of the rates of utilization of services is assumed by such person or the provider of such services.

''(4) INSURANCE POLICY.—For purposes of this subsection, the term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(5) PREMIUM.—For purposes of this subsection, the term 'premium' means the gross amount of premiums and other consideration (including advance premiums, deposits, fees, and assessments) arising from policies issued by a person acting as the primary insurer, adjusted for any return or additional premiums paid as a result of endorsements, cancellations, audits, or retrospective rating.

''(b) SELF-INSURED HEALTH PLANS.—

''(1) IN GENERAL.—In the case of a self-insured health plan which fails to meet the applicable standards specified in this chapter at any time during a calendar year, there is hereby imposed a tax equal to 25 percent of the health coverage expenditures for such calendar year under such plan.

''(2) LIABILITY FOR TAX.—The tax imposed by paragraph (1) shall be paid by the plan sponsor.

''(3) SELF-INSURED HEALTH PLAN.—For purposes of this subsection, the term 'self-insured health plan' means any plan for providing accident or health coverage if any portion of such coverage is provided other than through an insurance policy.

''(4) HEALTH COVERAGE EXPENDITURES.—For purposes of this subsection, the health coverage expenditures of any self-insured health plan for any calendar year are the aggregate expenditures for such year for health coverage provided under such plan.

''(c) LIMITATIONS ON IMPOSITION.—

''(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed under this section on any failure for which it is established to the satisfaction of the Secretary that none of the persons liable for the tax knew, or exercising reasonable diligence would have known, that such failure existed.

''(2) TAX NOT TO APPLY TO CERTAIN FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) or (b) on any failure if—

''(A) such failure was due to reasonable cause and not to willful neglect, and

''(B) such failure is corrected during the 30-day period beginning on the 1st date any person liable for the tax knew, or exercising reasonable diligence would have known, that such failure existed.

''(3) WAIVER BY SECRETARY.—In the case of a failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the tax imposed by this section to the extent that the payment of such tax would be excessive relative to the failure involved.

''SEC. 4987. NONDISCRIMINATION BASED ON HEALTH STATUS.

''(a) COVERAGE UNDER GROUP HEALTH PLANS.—A group health plan and a carrier offering health insurance coverage in connection with such a plan may not establish or impose eligibility, continuation, enrollment, or contribution requirements for an individual based on factors directly related to the health status, medical condition, claims experience, receipt of health care, medical history, disability, or evidence of insurability of the individual.

''(b) INDIVIDUAL COVERAGE.—

''(1) IN GENERAL.—A carrier offering health insurance coverage (other than in connection with a group health plan) may not establish or impose eligibility, continuation, or enrollment requirements for a qualifying individual (as defined in paragraph (2)) based on factors directly related to the health status, medical condition, claims experience, receipt of health care, medical history, disability, or evidence of insurability of the individual.

''(2) QUALIFYING INDIVIDUAL DEFINED.—For purposes of paragraphs (1), the term 'qualifying individual' means an individual who meets all of the following requirements:

''(A) The individual is in a period of qualifying previous coverage (as defined in paragraph (3)) which is at least 6 months long.

''(B) The individual is not eligible for coverage under any group health plan (including continuation coverage under section 4980B) and has not lost such coverage but for a failure to make required premium payments or contributions or due to fraud or misrepresentation of material fact.

''(C) If the individual's most recent coverage during the period of qualifying previous coverage under subparagraph (A) was health insurance coverage not in connection with a group health plan, such coverage was discontinued or terminated by the carrier only on the basis of—

''(i) a change in residence of the individual so that the individual no longer resided within a service area of a carrier with respect to such coverage, or

''(ii) a change in the individual's status so that the individual was no longer eligible for dependent coverage, if the individual previously was only eligible for such coverage as a dependent.

Nothing in subparagraph (C) shall be construed as preventing a carrier from waiving the application of such subparagraph during an annual open enrollment period or otherwise.

''(3) PERIOD OF QUALIFYING PREVIOUS COVERAGE DEFINED.—For purposes of this chapter, the term 'period of qualifying previous coverage' means the period—

''(A) beginning on the date an individual is enrolled under a group health plan or is provided health insurance coverage, and

''(B) ending on the date the individual is neither covered under a group health plan or covered under health insurance coverage (including coverage described in section 4991(2)(D)) for a continuous period of more than 2 months.

SEC. 4988. LIMITED USE OF PREEXISTING CONDITION EXCLUSIONS.

''(a) IN GENERAL.—A carrier offering health insurance coverage and a group health plan may impose a limitation or exclusion of benefits relating to treatment of a condition based on the fact that the condition is a preexisting condition (as defined in subsection (c)) only if the following requirements are met:

''(1) LIMITATIONS TO 3-MONTH LOCK-BACK.—The condition was diagnosed or treated during the period not more than 3 months before the date of enrollment for such coverage or under such plan.

''(2) LIMITATION ON EXCLUSION PERIOD.—

''(A) GENERAL RULE OF MAXIMUM OF 6-MONTH EXCLUSION.—Subject to paragraph (3), the limitation or exclusion extends for a period not more than 6 months (or 12 months in the case of a late enrollee described in subparagraph (B)) after such date of enrollment.

''(B) LATE ENROLLEE DESCRIBED.—

''(i) IN GENERAL.—Except as provided in clause (ii), a late enrollee described in this subparagraph with respect to a group health plan is an individual who becomes covered under the plan but who, at the time the individual first was eligible to elect such coverage, had elected not to be covered under the plan.

''(ii) EXCEPTION FOR INDIVIDUALS WITH CONTINUOUS COVERAGE.—An individual shall not be considered to be a late enrollee with respect to a plan if the individual establishes that, with respect to the period beginning on the date the individual first could have obtained coverage under the plan and until the date the individual was so covered, there was no period of more than 2 months during all of which the individual neither had health insurance coverage (including coverage described in subparagraph (C) or (D) of section 4991(2)) or was covered under any group health plan.

''(3) CREDIT FOR PREVIOUS QUALIFYING COVERAGE.—In the case of an individual who is in a period of qualifying previous coverage (as defined in section 4987(b)(3)) as of the date of enrollment for health insurance coverage or under the group health plan, the limitation or exclusion period under paragraph (2)(A) shall be reduced by the length of such period of qualifying previous coverage.

''(4) EXCEPTION FOR TREATMENT OF PREGNANCY.—The limitation or exclusion does not apply to treatment relating to pregnancy.

''(5) EXCEPTION FOR CERTAIN DEPENDENT COVERAGE.—

(A) NEWBORNS.—The limitation or exclusion does not apply to a child who has health insurance coverage (or is covered under a group health plan) as a dependent within 1 month of the birthdate until such time as the child does not have such coverage (or is not so covered) for a continuous period of more than 2 months.

(B) ADOPTED CHILDREN.—The limitation or exclusion does not apply (beginning on the date of adoption) to an adopted child who has health insurance coverage (or is covered under a group health plan) within 1 month of such date until such time as the child does not have such coverage (or is not so covered) for a continuous period of more than 2 months.

''(b) LIMITATION ON USE OF DELAYED COVERAGE IN LIEU OF PREEXISTING EXCLUSION LIMITATIONS.—

''(1) IN GENERAL.—A carrier offering health insurance coverage and a group health plan providing coverage, with respect to an individual, may delay the effective date of coverage of the individual beyond the first date of the month beginning after the date of election of the coverage only if the following requirements are met:

''(A) LIMITATION ON DELAY PERIOD.—Subject to paragraph (2), such additional delay does not extend over a period of longer than 2 months (or 3 months in the case of a late enrollee described in subsection (a)(2)(B)).

''(B) NO SUBSEQUENT APPLICATION OF ANY PREEXISTING EXCLUSION.—After the period of such additional delay, no limitation or exclusion described in subsection (a) may be applied.

''(C) NO PREMIUMS.—No premium or required contribution may be charged for the period before the effective date of coverage. Nothing in this paragraph shall waive the applicable requirements of subsection (a).

''(2) VOLUNTARY WAIVER.—The additional delay may extend over a period longer than the period specified under paragraph (1)(A) if the individual involved waives the protection provided under such paragraph.

''(c) PREEXISTING CONDITION DEFINED.—For purposes of this section, the term 'preexisting condition' means, with respect to coverage under health insurance coverage or under a group health plan, a condition which was diagnosed or treated for a condition, or for which a reasonably prudent person would have sought medical care diagnosis or treatment, within the 3-month period ending on the day before the date of enrollment (without regard to any delayed coverage period).

''SEC. 4989. GUARANTEED RENEWABILITY OF HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Except as provided in subsection (b), a carrier offering health insurance coverage shall guarantee that such coverage may be renewed or continued in force at the option of the policyholder or contractholder.

''(b) GROUNDS FOR REFUSAL TO RENEW.—

''(1) IN GENERAL.—Subject to paragraphs (3) and (4), a carrier offering health insurance coverage may cancel or refuse to renew such coverage—

''(A) for nonpayment of premium or contribution in accordance with the terms of the coverage;

''(B) for fraud or misrepresentation of material fact;

''(C) because of a general discontinuation or termination of coverage, but only if the carrier provides prior notice of such discontinuation or termination and if the conditions described in clause (i) or (ii) of paragraph (2)(A) are met;

''(D) in the case of coverage offered in connection with a group health plan, for failure of the plan to maintain participation rules consistent with paragraph (4); or

''(E) in the case of coverage that is continuation coverage under section 4980B, for loss of eligibility to continue such coverage.

''(2) CONDITIONS FOR DISCONTINUATION.—

''(A) IN GENERAL.—

''(i) NONDISCRIMINATORY SUBSTITUTION OF ALTERNATIVE COVERAGE.—The conditions described in this clause are the following:

''(I) The carrier is no longer offering health insurance coverage to new policyholders or contractholders.

''(II) The carrier is offering to the previously covered policyholder or contractholder the option to purchase any other health insurance coverage currently being offered to new policyholders or contractholders.

''(III) The discontinuation or termination of coverage and option to replace with other coverage is made uniformly without regard to the health status or insurability of any person provided health insurance coverage.

''(ii) GENERAL DISCONTINUATION OF COVERAGE IN A STATE.—The conditions described in this clause are that the carrier is discontinuing and not renewing all health insurance coverage within a class of coverage (as defined in subparagraph (B)) in a State.

''(B) CLASSES OF COVERAGE.—For purposes of subparagraph (A)(ii), each of the following is considered a separate class of health insurance coverage:

''(i) INDIVIDUAL COVERAGE.—Health insurance coverage not offered in connection with any group health plan.

''(ii) SMALL EMPLOYER GROUP COVERAGE.—Health insurance coverage offered to small employers (as defined by State law) in connection with any group health plan for covered employees and their dependents.

''(iii) OTHER GROUP COVERAGE.—Health insurance coverage offered in connection with a group health plan and not described in clause (ii).

''(3) APPLICATION OF GEOGRAPHIC LIMITATIONS TO COVERAGE PROVIDED THROUGH A NETWORK ARRANGEMENT.—

''(A) IN GENERAL.—Coverage under health insurance or under a group health plan that consists primarily of coverage through a network arrangement (as defined in subparagraph (B)) may be denied to individuals who neither live nor reside in the service area of the arrangement, but only if such denial is applied uniformly, without regard to the health status or the insurability of particular individuals.

''(B) NETWORK ARRANGEMENTS.—For purposes of subparagraph (A), the term 'network arrangement' means, with respect to a group health plan or under health insurance coverage, an arrangement under such plan or coverage whereby providers agree to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

''(4) MINIMUM PARTICIPATION REQUIREMENTS.—A carrier that offers health insurance coverage in connection with a group health plan that covers the employees of one or more employers may require that a minimum percentage of eligible employees of such an employer obtain such coverage if such percentage is applied uniformly to all such coverage offered to employers of comparable size.

''SEC. 4990. RELATION TO STATE STANDARDS.

''Nothing in this chapter shall prevent a State from establishing, implementing, or continuing in effect standards related to health insurance coverage (including the issuance, renewal, or rating of such coverage) if such standards are at least as stringent as the standards established under this chapter with respect to such coverage.

''SEC. 4991. DEFINITIONS.

''For purposes of this chapter—

''(1) CARRIER.—The term 'carrier' means—

''(A) a licensed insurance company;

''(B) an entity offering prepaid hospital or medical service plan;

''(C) a health maintenance organization; and

''(D) any similar entity which (i) is engaged in the business of providing a plan of health insurance or health benefits or services and (ii) is regulated under State law for solvency.

''(2) HEALTH INSURANCE COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'health insurance coverage' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract offered by a carrier.

''(B) EXCEPTION.—Such term does not include any of the following (or any combination of the following):

''(i) Coverage only for accident, dental, vision, or disability income, or any combination thereof.

''(ii) Medicare supplemental health insurance.

''(iii) Coverage issued as a supplement to liability insurance.

''(iv) Liability insurance, including general liability insurance and automobile liability insurance.

''(v) Workers' compensation or similar insurance.

''(vi) Automobile medical-payment insurance.

''(vii) Coverage providing wages or payments in lieu of wages for any period during which an employee is absent from work on account of sickness or injury.

''(viii) A long-term care insurance coverage, including a nursing home fixed indemnity policy (unless the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and of the Treasury, determines that such coverage is sufficiently comprehensive so that it should be treated as health insurance coverage.)

''(ix) Any coverage not described in any preceding clause which consists of benefit payments, on a periodic basis, for a specified disease or illness or period of hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate.

''(x) Such other coverage as the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and of the Treasury, determines is not health insurance coverage.

''(C) TREATMENT OF STATE RISK POOLS.—Except for purposes of sections 4987(b)(3), 4988(a)(2)(B)(ii), and 4988(a)(3), such term does not include coverage provided through a State risk pool, uncompensated care pool or similar subsidized program.

''(D) PUBLIC PLANS COUNTED FOR PURPOSES OF QUALIFYING PREVIOUS COVERAGE.—For purposes of sections 4987(b)(3), 4988(a)(2)(B)(ii), and 4988(a)(3), such term also includes coverage under any of the following:

''(i) The medicare program under title XVIII of the Social Security Act.

''(ii) A State plan under title XIX of such Act.

''(iii) A program of the Indian Health Service.

''(iv) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) under title 10, United States Code.

''(v) Any other similar governmental health insurance program (including a program described in subparagraph (C)).

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term in section 5000(b)(1), but does not include any type of coverage excluded from the definition of health insurance coverage under paragraph (2)(B) or (C) and does not include any plan unless at least one of the following requirements is met:

''(A) Any portion of the premium or benefits under the plan is paid by or on behalf of the employer.

''(B) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium.

''(C) The health benefit plan is treated by the employer, or any of the eligible employees or dependents, as part of a plan or program for the purposes of section 162, section 25, or section 106 of the Internal Revenue Code of 1986.

''(4) STATE.—The term 'State' includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to individuals who commence health insurance coverage or coverage under a group health plan after the first day of the first month beginning more than 6 months after the date of the enactment of this Act.

(2) PLAN YEAR EXCEPTION.—Such amendments shall not apply to plan years ending before the first day referred to in paragraph (1).

(c) CLERICAL AMENDMENT.—The table of chapters for subtitle D is amended by inserting after the item relating to chapter 44 the following new item:

''CHAPTER 45. Continuity and portability of health coverage.''

SEC. 3. CHANGES IN COBRA CONTINUATION REQUIREMENTS.

(a) MORE AFFORDABLE COVERAGE THROUGH REQUIREMENT OF LOWER-COST HEALTH PLAN CHOICES.—

(1) IN GENERAL.—Section 4980B(f) of the Internal Revenue Code of 1986 is amended—

(A) in paragraph (1), by striking '', continuation coverage under the plan'' and inserting ''and as selected by the qualified beneficiary under this subsection, continuation coverage of the type described in subparagraph (A), (F)(i), or (F)(ii) of paragraph (2)'';

(B) in paragraph (2)(A), by striking ''The coverage'' and inserting ''Unless the coverage is the type of coverage described in clause (i) or (ii) of subparagraph (F), the coverage'';

(C) in paragraph (2)(C)—

(i) in clause (i), by inserting ''(or in the case of alternative continuation coverage described in clause (i) or (ii) of subparagraph (F), 69 percent or 52 percent, respectively, of such applicable premium)'' after ''for such period'', and

(ii) in the last sentence by inserting '', '69 percent', or '52 percent'' after '' '102 percent'' and by inserting '', '100 percent', or '75 percent', respectively,'';

(D) by adding at the end of paragraph (2) the following new subparagraph:

''(F) TYPES OF ALTERNATIVE CONTINUATION COVERAGE REQUIRED.—

''(i) COVERAGE WITH TWO-THIRDS ACTUARIAL VALUE.—The type of coverage described in this clause is coverage which—

''(I) has an actuarial value (determined with respect to the similarly situated beneficiaries referred to in subparagraph (A)) of not less than ⅔ of the actuarial value (determined with respect to such beneficiaries) of the reference coverage, and

''(II) meets the requirements of clause (iii).

''(ii) COVERAGE WITH ONE-HALF ACTUARIAL VALUE.—The type of coverage described in this clause is coverage which—

''(I) has an actuarial value (determined with respect to the similarly situated beneficiaries referred to in subparagraph (A)) of not less than ½ of the actuarial value (determined with respect to such beneficiaries) of the reference coverage, and

''(II) meets the requirements of clause (iii).

''(iii) REQUIREMENTS RELATING TO GENERAL AVAILABILITY AND PREEXISTING CONDITIONS.—Coverage meets the requirements of this clause if the coverage—

''(I) is made available to all qualified beneficiaries who become eligible for coverage under this subsection after the effective date of this subparagraph, and

''(II) does not impose any restriction or limitation on coverage based on a preexisting condition unless such restriction or limitation could be imposed under the coverage described in subparagraph (A).

''(iv) REFERENCE COVERAGE DEFINED.—For purposes of this subparagraph, the term 'reference coverage' means, with respect to a group health plan, the costliest continuation coverage available under subparagraph (A) under the plan, excluding coverage in which an insignificant proportion of the eligible individuals is enrolled.''; and

(E) by adding at the end of paragraph (4) the following new subparagraph:

''(D) COMPUTATION BASED ON FULL COVERAGE.—For purposes of this section, the applicable premium shall be computed based on the type of coverage described in paragraph (2)(A).''

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after the first day of the first month beginning at least 6 months after the date of the enactment of this Act.

(b) CONTINUATION COVERAGE FOR CERTAIN FORMERLY COVERED DEPENDENT SPOUSES AND CHILDREN.—

(1) IN GENERAL.—Section 4980B(f) of such Code is amended by adding at the end the following new paragraph:

''(9) CAPTURE OF DELAYED DIVORCE OR SEPARATION.—

''(A) IN GENERAL.—For purposes of this section, if a covered employee disenrolls from coverage (or fails to renew coverage of) a qualified beneficiary within the 12-month period preceding the date of the divorce or legal separation of the employee from the employee's spouse, the divorce or separation shall be treated as a qualifying event described in paragraph (3)(C) and the loss of coverage shall be considered to be a result (and by reason) of such event.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to a qualified beneficiary if—

''(i) the beneficiary waives the rights under such subparagraph, or

''(ii) the qualified beneficiary at the time of the qualifying event or at the time of the disenrollment or failure to renew coverage has coverage under a group health plan (other than by reason of this paragraph) if the plan does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary.''

(2) TREATMENT OF PERIOD BEFORE DELAYED DIVORCE OR SEPARATION.—Subparagraph (D) of section 4980B(f)(2) of such Act is amended by adding at the end the following new sentence: ''For purposes of applying any preexisting condition limitation or restriction, any period beginning on the date of the disenrollment or failure to renew coverage referred to in paragraph (9)(A) and ending on the date of the divorce or separation referred to in such paragraph shall not be treated as a break in coverage if such paragraph applies to the qualified beneficiary.''.

(3) TREATMENT OF ANNULMENTS.—Section 4980B(g) of such Code is amended by adding at the end the following new paragraph:

''(5) TREATMENT OF ANNULMENT AS DIVORCE.—The term 'divorce' includes an annulment.''.

(4) EFFECTIVE DATE.—The amendments made by this section shall apply to divorces, legal separations, and annulments occurring more than 60 days after the date of the enactment of this Act.

(c) ELIMINATION OF TERMINATION OF CONTINUATION COVERAGE BY REASON OF MEDICARE ELIGIBILITY THROUGH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Subclause (II) of section 4980B(f)(2)(B)(iv) of such Code is amended by inserting ''other than by reason of section 226A of such Act'' after ''the Social Security Act''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to covered employees and qualified beneficiaries who become entitled to benefits under title XVIII of the Social Security Act pursuant to section 226A of such Act on or after the first day of the first month that begins after the date of the enactment of this Act.

THE MEDIGAP CONSUMER PROTECTION ACT OF 1995

HON. RICHARD J. DURBIN

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 11, 1995

Mr. DURBIN. Mr. Speaker, today I am introducing the Medigap Consumer Protection Act of 1995, which will help millions of seniors hang on to the private health insurance they purchase to pay for the deductibles and services which are not covered by Medicare.

In recent years, insurance companies have increasingly sold Medigap policies whose premiums are determined using a method known as ''attained age rating''. An attained age policy offers the buyer lower premiums at an early age but its premiums increase as a result of the aging of the policyholder. At various age thresholds the insurer raises premiums to reflect the expected greater use of health care by older policyholders. Due to the high inflation rate in the cost of health care, all Medigap policy premiums increase with time, but the premiums of attained age policies increase much more sharply.

The Medigap Consumer Protection Act would prohibit annual Medigap premium increases from being based on the age or aging of the policyholder. This would prohibit insurance companies from selling any more attained age Medigap policies. Ten States already prohibit attained age rating for Medigap: Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. The bill would allow people who have already purchased attained age policies to keep them if they choose to do so. However, insurance companies would have to offer these policyholders the option of changing their insurance coverage to a policy not based on attained age rating, for example, a community rated or issue age rated policy.

Most Medigap purchasers, and many insurance agents, do not understand how attained age rating works, so prospective policy buyers often have a difficult time in making an informed decision. Senior citizens who purchase attained age policies and later face unexpectedly large premium increases as they age find it difficult to change policies because they usually must face a 6-month waiting period for pre-existing health conditions. When seniors enter the Medicare system—usually at age 65—they have a 6-month window of opportunity during which they can sign up for Medigap insurance without being denied coverage because of pre-existing conditions. At all other times they are subject to such a pre-existing condition waiting period.